Child Death Review Report 1996

State of Hawaii Department of Health
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- *Office of Health Status Monitoring*
- *Public Health Nursing Branch*

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- *City and County of Honolulu*
- *Hawaii County*
- *Kauai County*
- *Maui County*

To the members of the Local CDR Teams who have been willing to step outside of their traditional professional roles to examine the circumstances that lead to child deaths and to consider ways to prevent other deaths, your work has created a viable CDR System in the State. We thank you for your courage and willingness to acknowledge that the death of a child is a community problem that demands community intervention. *(See Appendix I for membership of the State CDR Council and the Local CDR Teams.)*

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Mahalo to all for your kokua and laulima!

Mission of Hawaii's Child Death Review

The Hawaii Child Death Review System is empowered under Act 369 SLH 1997 to reduce the incidence of preventable child deaths. The mission statement adopted by the State CDR Council is:

"To reduce preventable child deaths through systematic multidisciplinary and interagency review of child deaths, from birth to under age 18, in the State of Hawaii."

Seven objectives were identified to achieve the Council mission:

1. To establish a State Child Death Review Council and Local Child Death Review Teams.
2. To describe child death trends and patterns in Hawaii.
3. To identify the causes and circumstances surrounding every child's death.
4. To identify risk factors in order to recommend the development of policies, strategies, and resources to prevent future child deaths.
5. To facilitate interdisciplinary training and community prevention education through data driven policy recommendations.
6. To establish a statewide data collection system to facilitate the Child Death Review effort.
7. To assure a collaborative response to prevent child deaths.

Executive Summary

The Hawaii State Child Death Review System is a community-based process that provides systematic, multidisciplinary and multiagency reviews of all child deaths under age 18 to reduce preventable child deaths. Through the review of the cause and circumstances that surround a child's death, trends and patterns may be described and risk factors may be identified in order to recommend change in policies, strategies and resources to prevent future child deaths.

Act 369 of the Session Laws of Hawaii in 1997 created the Hawaii CDR System, giving the Department of Health authority to conduct multidisciplinary reviews and to oversee the implementation of this system. Multidisciplinary representation includes individuals from public health, medicine, law enforcement, child welfare, education, the judiciary and other community professionals as appropriate.

The State CDR Council has the responsibility of on-going oversight for this review system. It recommends policy and legislative changes, facilitates training programs and increases public awareness through specific educational activities. As Local CDR Teams review the deaths, they also identify services, policies, educational and other factors that may have prevented the child's death. Together their collective knowledge motivates system change.

This document is based on the retrospective review of all 1996 child deaths. The findings are limited but largely consistent with patterns of child death previously identified in other studies. There are no marked differences between Hawaii and other states at present.

- 57% of all child deaths occur in the first year of life. The primary causes in this period were prematurity and congenital anomalies.
- Drowning is one of the leading categories of child deaths in 1-4 years, 5-9 years and 15-17 years.
- Motor vehicle crashes are the leading cause of death for 10-14 years and 15-17 years and the second leading category for 1-4 years and 5-9 years.
- The child death rate was highest for Samoans and Pacific Islanders, followed by Hawaiians who presented an above average rate.

Over time in depth analysis with large numbers will provide greater insights into the circumstances and risk factors surrounding the death of children in the State of Hawaii.

INTRODUCTION

Background

On the national level, interagency child death review teams also known as child fatality teams emerged in response to the increasing awareness of fatal violence against children in the United States. The first multiagency team originated in California in 1978. Subsequently, review teams began in other states, and today, almost every state has some form of a review process in place. Nationally the American Bar Association provided leadership to assure systematic reviews of child deaths with standardized procedures and protocols. The multidisciplinary and multiagency process involves the coordination and collaboration of resources and data collection from a variety of previously unrelated or loosely related systems. The overall purpose of the child death review process is the prevention of those child deaths that are preventable.

In 1991, the Department of Human Services (DHS) requested their Child Welfare Services State Advisory Council to conduct a retrospective review of child abuse and neglect deaths and serious reabuse cases covering a five year period from 1987 through 1992. The purpose of this review was to insure that "lessons learned" involving the death and serious re-injury of a child due to abuse and neglect would be identified and changes made within the system which would eliminate or reduce the chances of reoccurrence.

As a result of that review, two major findings surfaced. First, there were numerous problems in the current "system" and the "system" involved several agencies and entities other than DHS making it a more complex issue. Secondly, a more formal and collaborative effort needed to be pursued or developed in order to begin to improve the "system."

Consequently, the Sixteenth State Legislature passed resolutions creating a task force to work toward the establishment of an interdisciplinary CDR System to identify deaths from child abuse and neglect.

The final report from this task force to the legislature contained a description of the roles of the four major public agencies that function at a statewide level as well as other involved agencies situated at the city/county level. All members of this task force were requested to purchase and review five publications from the Child Fatalities Project-American Bar Association Center on Children and the Law to assist in creating a common framework from which to work. Several members also attended a training sponsored by the American Bar Association, bringing back valuable information that would guide the insuing activities.

In 1993, The Judicary was identified as the lead agency to oversee this effort. Shortly thereafter, the responsibility shifted to the Office of the Attorney General. A year later, the DOH assumed responsibility. Within the DOH, the program was eventually assigned a "home" in the Maternal and Child Health Branch (MCHB) of the Family Health Services Division (FHSD). The Legislature solidified this responsibility in 1997 by the passage of Act 369.

Act 369 which gives the authority to the DOH also clarifies the use of child death review information and records and defines the parameters of the review. *(See Appendix III for the Act 369)*

State Child Death Review Council:

The State CDR Council was charged with the responsibility of developing the system policies and procedures for the reviews and setting the framework for the program. Several subcommittees were formed to study issues and recommend policies. Focus areas included: Confidentiality, Data Collection and Protocols for State Council and Local Teams. During the first two years, the State CDR Council and subcommittees met monthly. This initial phase involved intensive research by the DOH and the State CDR Council members. The crafting of the system began with lively discussions around the creation of the data set and mock reviews.

Staffing needs were identified and the search for funding began. The Research Statistician funded by the Preventive Health and Health Services Block Grant (PHHSBG) would be situated in the Office of Health Status Monitoring. The CDR Nurse Coordinator would be housed at the MCHB. Later funding for this position was secured from the DHS.

As plans became operational, two extremely important training events occurred in 1998 in preparation for the actual reviews. These were:

(1) August, 1998: Hawaii Child Death Review: Orientation for Local Teams to introduce Local CDR Team members to the CDR system and the policy and procedure manual with data collection forms; and

(2) October, 1998: Hawaii Child Death Review System: Intensive Training Conference for all stakeholder in the CDR System including team members, community leaders, key agency personnel, legislators and child advocates.

By December, 1998, the identification of team members by their respective Departments on each island was completed and organizing efforts for each team had begun. DOH personnel were designated as coordinators for each civilian team. The CDR Nurse Coordinator would serve as liaison to oversee all team activities including the Department of Defense Team.

Local Child Death Review Teams:

Child Death Review is a community-based process. Department of Health personnel from each island augment as team coordinators in these reviews. Local CDR Team membership is specific to that county with support and technical assistance from the MCHB. There are five civilian teams in four counties (Honolulu county has two teams due to the higher number of deaths), and a Department of Defense Team with membership representative of all branches of the Armed Forces.

The team completes a case report for every death reviewed. This report is submitted to the Maternal and Child Health Branch, where the information is entered into a database. Aggregate analysis and reporting takes place when the year reviews are complete. *(See Appendix II for the Data Form 1 and Form 2)*

Local CDR Teams are charged to conduct a comprehensive, retrospective analysis of all deaths of resident and visitor children who die in their jurisdictions. If a child dies in a jurisdiction outside of his residence, there are two retrospective reviews of the death, one in the county of the child residence and one in the county where the death occurred. This also applies to a military dependent whose death occurs in the civilian community. When available and in accordance with confidentiality provisions, each team member shares his or her agency's knowledge of the child and family circumstances surrounding the death and the agency's response to the death. The Statute assures the review team's access to the necessary information both from public agencies and private sources.

The team discusses *who, where, when* and *why* of every death. Other appropriate individuals who have special knowledge as the child's physician or case worker are invited to become ad-hoc team members for the case review. These individuals are subject to the rules of the CDR process during this period.

The team attempts to answer the following questions:

- Is our review complete?
- Are there services that have been or should be provided?
- Are there other children at imminent risk of harm?
- What were the risk factors involved in this death?
- Are there agency policies and practices that should be changed?
- What are we going to do to prevent a similar death?

The Local CDR Team meetings are closed and secured with strictest confidentiality maintained as mandated by Statute and outlined in the procedure manual. During the reviews, private individuals may be requested to provide pertinent information to the team. At each team meeting, members and invited attendees are required to sign a statement of confidentiality. This statement states that the information secured through a review will remain confidential and not be used for reasons other than that for which it was intended.

Review of Hawaii Child Death Review Pilot Project
1996 Data

Introduction

The Hawaii CDR System through the Local CDR Team process completed the retrospective review of child deaths in1996 as a pilot project. Due to the small numbers of data, analysis of statistical information to identify patterns, trends and possible predictors of child deaths was not possible. Identification of systemic strengths and weaknesses as they impact on the identification of risk in the prevention of child deaths has begun. Recommendations for changes in procedures and service delivery systems which influence the well being of children and families will be developed as more information is gained from these reviews. Identification and development of public health policies and laws across the system that cares for children and families will be highlighted in future reports.

Review of all cases of death for the year 1996 in Hawaii revealed a total of 192 deaths from birth to 18 years of age for a rate of 64.2/100,000 population per year. Although this number is far greater than one would like, it represents an overall child death rate comparing favorably to other states.

The Hawaii CDR System seeks to add to information revealed by death certificates submitted to vital statistics alone. The assembly of multidisciplinary teams allows for variables pertinent to the deaths of individuals between birth and 18 years of age to be included in the review. The physician assigning the cause of death on the death certificate may have limited information. From the added information available to the Local CDR Teams, a small but significant number of deaths were reclassified as to cause. One death designated as due to natural causes by death certificate was deemed a homicide by the review team. Some specific causes of death such as Sudden Infant Death Syndrome (SIDS) on death certificate were reclassified as undetermined. This reflects that additional information may raise questions as to the true cause of death, but still be insufficient to make a confident reassignment. In such cases it is preferable to deem them undetermined, rather than assign them to a specific category even though evidence is conflicting.

In order to potentially further define the death risks experienced by this population, the 1996 Hawaii deaths have been divided into groupings for analysis.

Causes of Death by Age Group

The numbers of deaths, with causes of death listed for each of six age groupings, are shown in Table I. This table includes all deaths, including nonresidents, and the causes of death are those designated by the Local CDR Teams rather than by death certificate. The majority of child deaths occur in the first year of life. Of the 18 years of childhood, the first year accounted for 57% of all childhood death with 110 deaths. Accepted health statistical groupings separate the first year of life into two periods. The neonatal period, the first 28 days of life, carries the highest risk of death with a total of 70 deaths. The primary causes of death in this period were prematurity (50),

congenital anomalies (13) and birth injury (5). These deaths almost all occur in the hospital from conditions that are recognized at birth. Prevention efforts for this age group should focus on addressing risk factors during pregnancy known to affect neonatal outcomes. Several current programs within the state are addressing risk factors including maternal poor nutrition, lack of medical care, substance use and exposure to domestic violence.

The post-neonatal period, from 28 days through the first year of life, is the second highest risk period with a total of 40 deaths. There continue to be deaths related to adverse birth conditions such as prematurity and congenital anomalies, but also deaths are now occurring in the community due to preventable incidents such as suffocation (2) drowning (1) and fire (1). Five deaths were attributed to SIDS. SIDS is defined as "the sudden death of an infant under one year of age that remains unexplained after a complete investigation, which includes an autopsy, examination of the death scene, and review of the symptoms of illnesses the infant had prior to dying and any other pertinent medical history." This definition of SIDS has led overall to more vigorous efforts to obtain pertinent information around infant deaths and probably more specific assignment of causes of death than had previously occurred. The CDR process has assisted in assembling existing information, but still after review of individual cases, information may not be sufficient to reliably differentiate between SIDS, suffocation, respiratory conditions and homicide and the cause may be classified "undetermined" as occurred in 5 cases of infant death.

Epidemiologic evidence suggesting that SIDS was related to infants sleeping face down led to the nationwide "Back to Sleep Campaign". Since its initiation, the U.S. and Hawaii rates for SIDS have dropped significantly. Efforts to have all childcare providers and health care workers emphasize sleeping risks in their practice and their counseling should continue.

In the age group 1-4 years of age, there were a total of 24 deaths. The distribution of causes of death show 14/24 deaths (58%) were due to medical conditions with 6 due to chronic disease, 3 due to acute illness, 3 due to congenital anomalies and 2 due to cancer. There were 9/24 (38%) due to injury with, 4 due to drowning, 3 vehicular deaths, 1 due to suffocation and 1 due to physical assault.

In the age group 5-9 years of age, there were a total of 16 deaths with 8/16 (50%) due to medical conditions and 7/16 (44%) due to injury. There were 4 vehicular deaths, 1 drowning, 1 physical assault and 1 fire. One death was of undetermined cause.

In the age group 10-14 years of age, there were a total of 18 deaths with 10/18 (56%) due to medical conditions and 8/18 (44%) due to injury. There were 5 vehicular deaths accounting for 28% of all deaths, 2 due to drowning and 1 death due to suicide.

In the age group 15-17 years of age, there were a total of 24 deaths. The causes of death were medical in 7/24 (29%), and 17/24 (71%) were due to injury. The rise in injury deaths is primarily attributable to the increase of deaths from motor vehicle incidents accounting for 10/24 or 42% of all deaths in this age group. There were 2 deaths due to drowning, 2 from assault, 2 from suicide and one unintentional injury from a firearm.

Table 1
Leading Causes of Child Deaths by Age Groups, Hawaii 1996 (N=192)

Neonates (First 28 days of life) (Total Deaths = 70)		Post-neonates (28 Days up to 1 year) (Total Deaths = 40)		1-4 Year Olds (Total Deaths = 24)	
Prematurity	50	Congenital Anomalies	8	Chronic Disease/Illness	6
Congenital Anomalies	13	Prematurity	8	Drowning	4
Birth Injury	5	Undetermined	5	Vehicular	3
Suffocation/Asphyxiation	1	SIDS	5	Acute Illness	3
Undetermined	1	Acute Illness	3	Congenital Anomalies	3
		Chronic Disease/Illness	3	Cancer	2
		Suffocation/Asphyxiation	2	Suffocation/Asphyxiation	1
		Genetic Anomalies	2	Physical Assault	1
		Status Post Surgical	2	Undetermined	1
		Drowning	1		
		Fire/Burn	1		
5-9 Year Olds (Total Deaths = 16)		**10-14 Year Olds (Total Deaths = 18)**		**15-17 Year Olds (Total Deaths = 24)**	
Acute Illness	4	Vehicular	5	Vehicular	10
Vehicular	4	Cancer	4	Chronic Disease/Illness	3
Cancer	2	Acute Illness	3	Drowning	2
Drowning	1	Chronic Disease/Illness	3	Cancer	2
Physical Assault	1	Drowning	2	Physical Assault	2
Chronic Disease/Illness	1	Suicide	1	Suicide	2
Fire/Burn	1			Acute Illness	2
Genetic Anomalies	1			Firearm	1
Undetermined	1				

***The total number of child deaths is 192 (including residents and nonresidents).**

As can be seen in Table 1, after the first year of life, there are only a few deaths in each category of cause of death. This precludes confident statements as to the statistical significance of any apparent trends. Indeed, the numbers are so few that although much data is collected during each case review which relates to specific categories such as vehicular death, drowning or homicide, trending related to risk factors is difficult. There will be greater opportunity to identify trends and specific risk factors in our community with the further accumulation of years of data and refinement of our data analysis.

With only one year's data, several potential areas for prevention are already apparent. The category responsible for the most preventable deaths is motor vehicle. There were 18 resident deaths classified as vehicular. There was 1 bicyclist death in a 6 year old cycling unsupervised without a helmet. There were 2 pedestrian deaths, 1 death in a 7 year old and the other a 2 year old. The 2 year old was in the mother's arms at the time of impact and they were not in a crosswalk. There were 7 drivers, two of whom were only 13 years of age. One died driving a dirtbike (helmet status unknown) the other was driving a stolen car. Two drivers who died were speeding and one was intoxicated. Of the 8 occupant deaths one was a 14 year old in a truck bed. There were 5 of 13 restrained in some fashion while 5 were definitely not and 3 did not have restraint status determined. The age of occupants who died was greater than 12 in 6/8 (75%), there was one 9 year old (unrestrained) and one was 3 (reported restrained in some way). The bicycle and pedestrian deaths all occurred on Oahu. Nine of the fifteen (60%) killed in vehicles were on the neighbor islands (5 on Maui, 3 on Hawaii, 1 on Kauai). This is clearly a large number of vehicular deaths for the neighbor islands as compared to Oahu when their smaller population is considered.

Prevention strategies are needed to specifically address each age group. Current prevention programs which have been proven to be effective include using age appropriate restraints that are correctly installed, positioning of child passengers, and enforcing traffic laws and graduated licensing for teenager drivers. However, these efforts need to be maintained and strengthened.

Drowning is a significant cause of death in childhood in Hawaii. It is the second leading cause of injury death after the vehicular category. This is not surprising considering our marine environment and the number of pools in our state. There were 4 drownings in pools, 3 in the ocean, one in a river and one in a bathtub. All the pool deaths were in very young children while the ocean river deaths were in children over the age of 13. None of the victims were known to be wearing a flotation device. None of the cases were attended by a lifeguard (unknown in 1 case). Drowning in early childhood is primarily due to lack of age appropriate supervision by adults whereas in later childhood risk taking behavior on the part of the child may also play a role. Although supervision can prevent drowning, this requires behavior change and overall efforts to improve parenting. Teaching children to swim at an appropriate age is important, but cannot substitute for appropriate supervision. Efforts to create environments where drowning is less likely to occur by having barriers for young children and reduced access to dangerous swimming spots will also be effective.

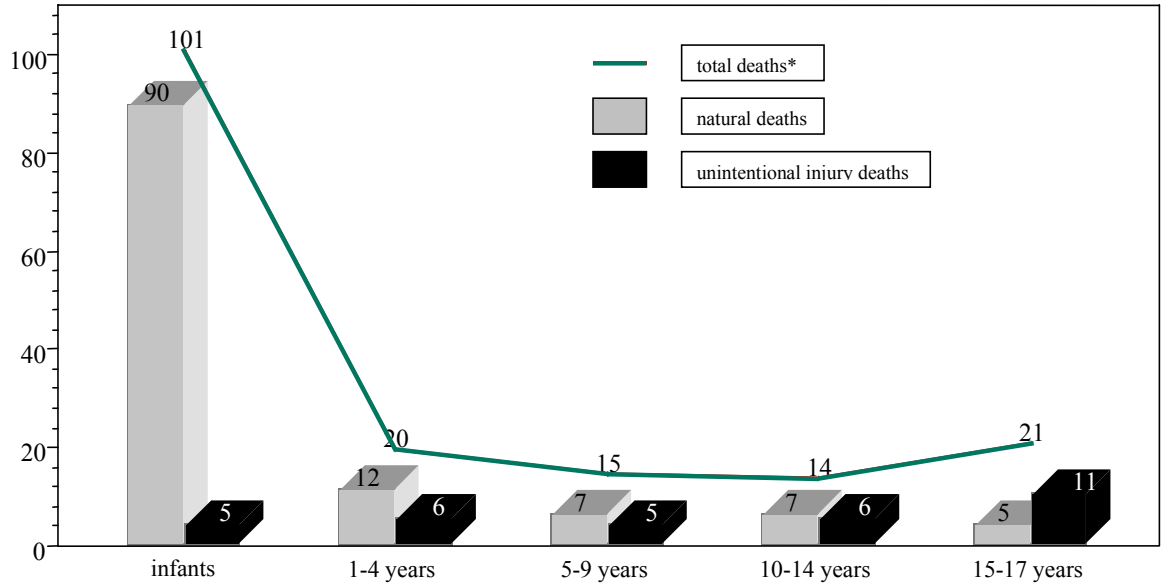
Suffocation was a significant cause of death for very young children. Three victims were infants and one was 2 years old. The 2 year old choked on popcorn. An unsuccessful Heimlich maneuver was attempted. One infant suffocated when its breathing was obstructed by plastic, one was wedged between the mattress and rungs of a playpen and one was deemed to be due to a parent overlying the infant in bed when co-sleeping.

Two siblings ages 8 years and 1 year died in the same house fire while the adults survived. There was a smoke detector that functioned properly. The review team revealed family risk factors which contributed to the deaths.

Figure 1 shows the distribution of child deaths by age groups. It also shows the number of deaths due to natural causes (medical) vs. unintentional injury in each age group. These deaths are for residents of Hawaii only. Individuals visiting Hawaii or being transferred here for medical care may not have the same age distribution as our population so removing those deaths for the purpose of this figure gives a more accurate picture of the age-related risk of our population. Infant deaths are most likely to be due to medical conditions. After infancy, unintentional injury causes approximately half of all deaths until adolescence when the risk of death from injury exceeds the risk of dying of a medical condition.

Intentional injury is not included in this table as the numbers are small but it is an important category in terms of prevention. There were a total of 6 deaths due to intentional injury. These deaths included 3 suicides (one each in Hawaii, Honolulu and Kauai counties). All suicides occurred by hanging. The suicides occurred in one female with a history of alcohol abuse and running away and the two males apparently had no antecedent history of mental health problems. There were 4 homicides, all in Honolulu. Two were teenagers. Aggregate risk factors for intentional injury cannot be elucidated by this data but thorough review does lead to insights on individual cases and opportunities to improve services.

Figure 1
Number of child deaths in Hawaii, by manner and age of victim, 1996.



Methods: Includes only deaths among residents of Hawaii (n=171).

*** "Total deaths" include 3 suicides (one in the 10-14 year group, and 2 in the 15-17 year group), 3 homicides (1 among 5-9 year olds, 2 among 15-17 year olds), 1 death due to legal intervention (15-17 year age group), and 10 other deaths for which the intent could not determined by the review teams (6 among infants, 2 among 1-4 year olds, and 2 among 5-9 year olds).**

Table 2 shows the Hawaii population and deaths for each age group and age specific death rates by manner of death. Only residents of the state are included for this table. Age specific death rates are based on small numbers except for the infant age group and may not be accurate. The death rate for infants is by far the highest while the rate in middle childhood is the lowest. The infant death rate is 586.4/100,000, while the second highest rate is for the 15-17 year age group where the rate is 44.4/100,000 and the lowest death rate of 17.4/100,000 occurs in middle childhood

Table 2
Number and rate of child deaths in Hawaii, by manner and age of victim, 1996.

		Number of Deaths			Rate of deaths (/100,000 pop'n)		
Age group	1996 population	Total*	Natural	Unintentional injury	Total*	Natural	Unintentional injury
Infants	17,224	101	90	5	586.4	522.5	29.0
1-4 years-olds	73,220	20	12	6	27.3	16.4	8.2
5-9 years-olds	86,301	15	7	5	17.4	8.1	5.8
10-14 years-olds	80,344	14	7	6	17.4	8.7	7.5
15-17 years-olds	47,299	21	5	11	44.4	10.6	23.3

*** "Total deaths" include 17 deaths that were not classified as natural or due to unintentional injuries.**
These deaths included 3 suicides (one in the 10-14 year group, and 2 in the 15-17 year group), 3 homicides (1 among 5-9 year olds, 2 among 15-17 year-olds), 1 death due to legal intervention (15-17 year age group), and 10 other deaths for which the intent could not be determined by the review teams (6 among infants, 2 among 1-4 year-olds, and 2 among 5-9 year-olds).

Methods: Includes only deaths among residents of Hawaii (n=171). The source for 1996 population estimates are from Population Estimate Reports from the U.S. Bureau of the Census, as listed on the DBEDT website (http://www.hawaii.gov/dbedt/estimate.html).

Note: The low number of deaths make all rate calculations unreliable, with the exception of infants.

Resident Status and Geographic Distribution

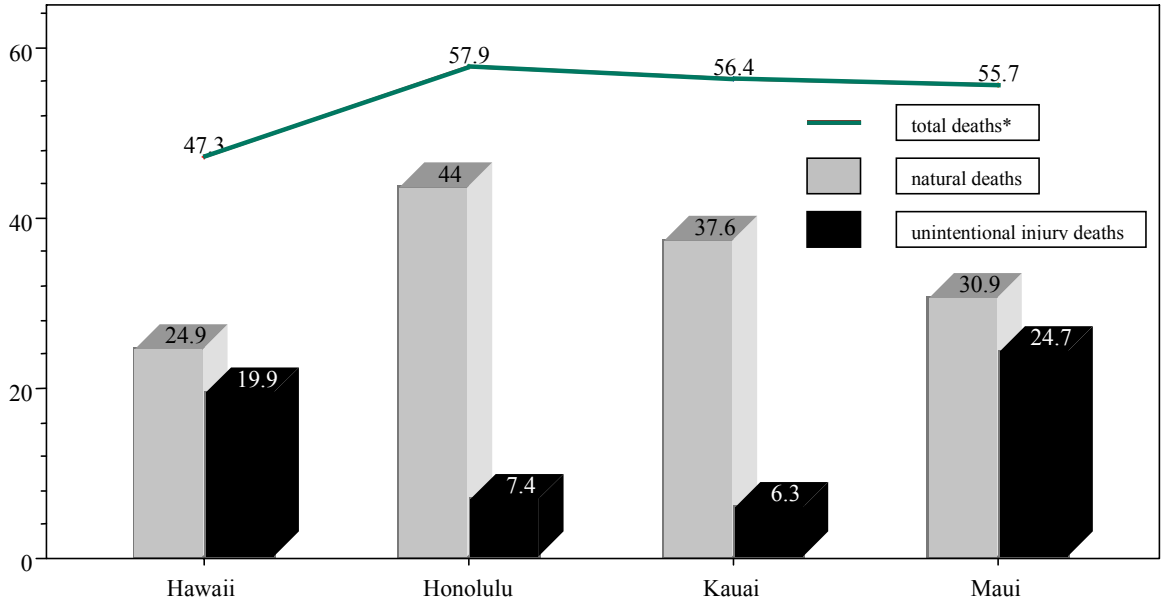
The overall child death rate for Hawaii of 64.2/100,000 reflects all child deaths occurring in the state in 1996. It is recognized that Hawaii has substantial numbers of visitors and also receives medical transfers from the Pacific Basin of children in critical condition who may subsequently die here. When the nonresident deaths are removed for calculation, the overall child death rate is 57.2/100,000 population. **Table 3 shows the numbers of deaths for nonresidents and the numbers of deaths in each County**. These are further broken down into numbers for unintentional injury and natural (medical) deaths. There were 21 child deaths occurring in nonresidents of the total 192 accounting for 5% of the 1996 child deaths. The 21 non-resident deaths included 15 deaths due to natural causes with 2 due to acute illness, 4 due to cancer, 4 due to congenital anomalies, 2 to chronic disease and one death each from birth injury, surgical procedure and prematurity. Six deaths were due to injury with 4 due to motor vehicles, one drowning and one homicide.

Table 3
Table of Resident County by Death Manner

Frequency	Natural	Unintentional/ Accidental	Intentional	Undetermined	Total
Nonresident	15	5	1	0	21
Hawaii	10	8	1	0	19
Honolulu	102	16	4	3	125
Kauai	7	1	1	0	9
Maui	10	8	0	0	18
Total	144	38	7	3	192

The majority of child deaths occurred in Honolulu County because of the large population concentration in this county. **Figure 2 shows the rate of child death by county of residence.** The rates for natural deaths appear to be highest in Honolulu and injury death rates appear higher on the neighbor islands. Apparent differences in rates may not be significant as the numbers of deaths occurring outside Honolulu County are small. Further accumulation of data is needed to make confident statements about the effect of county of residence on risk of death.

Figure 2
Rate (/100,000 population) of child deaths in Hawaii, by manner of death and county of residence, 1996.



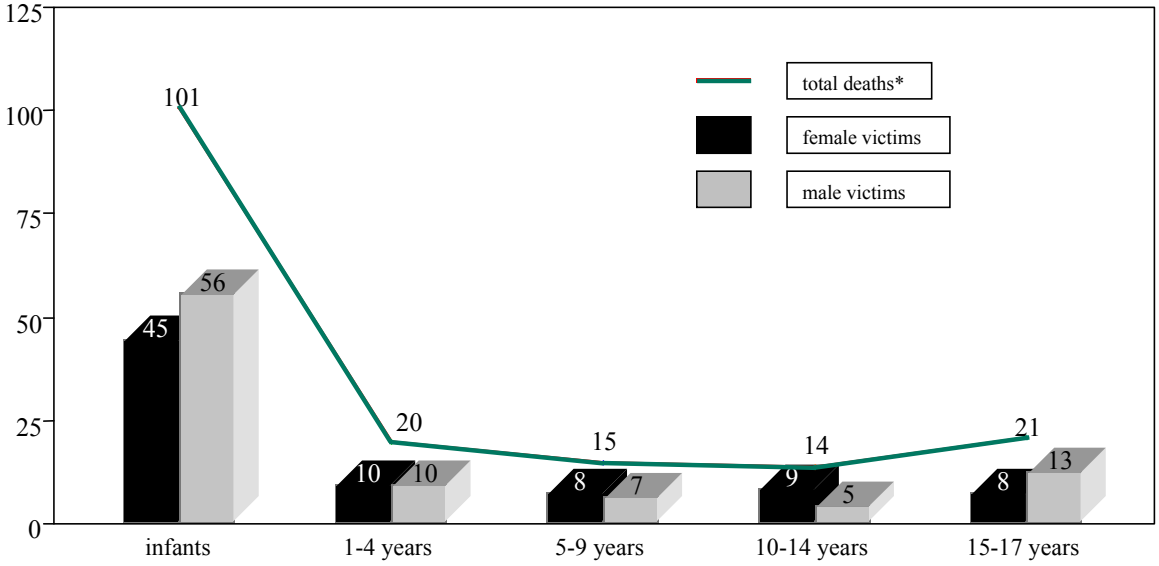
Methods: Includes only deaths among residents of Hawaii (n=171). Rates are crude mortality rates for residents aged 0-17 years. The source for 1996 population estimates are from Population Estimate Reports from the U.S. Bureau of the Census, as listed on the DBEDT website (http://www.hawaii.gov/dbedt/estimate.html).
*** "Total deaths" include 17 deaths which were not classified as natural or due to unintentional injuries.**
These deaths included 3 suicides (one each among residents of Hawaii, Honolulu and Kauai counties), 3 homicides (all in Honolulu), 1 death due to legal intervention in Honolulu, and 10 other deaths for which the intent could not be determined by the review teams (9 in Honolulu, and 1 in Kauai counties).

Note: The low number of deaths make all rate calculations unreliable, with the exception of natural deaths among residents of Honolulu.

Gender

Figure 3 shows the distribution of child deaths by age group and gender among residents of Hawaii. There are differences in distribution of death by gender for some age groups but the differences are again interpreted with caution due to the small numbers. Overall, 53% of the victims were male. Males have a higher risk in the neonatal period and in adolescence in this cohort, consistent with other studies on larger populations. The increase risk for males in the neonatal period is not well understood. The increase risk for males in adolescence nationally is attributable to an increase rate of death from motor vehicle incidents, suicide and assault.

Figure 3
Number of child deaths in Hawaii, by age and gender of victim, 1996.



Methods: Includes only deaths among residents of Hawaii (n=171).

Ethnicity

Table 4 shows the rate of death by ethnicity. The Department of Health, Office of Health Status Monitoring estimates the size of ethnic groups based on information gathered by the Hawaii Health Survey. These estimates were used to calculate child death rates for ethnic groups. There are multiple problems with estimates of the size of ethnic populations and the determination of ethnic category of individuals. Rates for ethnic groups having less than 5 child deaths were not calculated. With this in mind, some observations may be noted. Three ethnic groups had death rates higher than the overall death rate. The child death rate was highest for Samoans and Pacific Islanders followed by Hawaiians. Analysis of the determinants of these ethnic disparities is necessary to gain in sight as to the relationship of ethnicity to the death of children.

Table 4
Child Deaths and Estimated Child Death Rate by Ethnicity of Residents, Hawaii 1996

Ethnicity of Child	Estimated Population Less than age 18	Number of Child Deaths	Estimated rate per 100,000
Samoan/Tongan/Other Pacific Island	6,489	15	231.2
Hawaiian*	98,329	75	76.3
Black	14,392	9	62.5
Filipino	49,107	26	52.9
White**	47,914	22	45.9
Japanese	48,480	15	30.9
Other***	32,829	9	27.4
State		171	57.3

***Includes Hawaiian and Part Hawaiian**
****Includes Portuguese**
*****Ethnicities with < 5 child deaths**
Estimated population is based on Hawaii Health Survey

Appendix I

Hawaii State CDR Council
and
Local CDR Team Members

Looking To The Future

A major goal of Hawaii's Child Death Review system is to prevent child deaths. This 1996 Child Death Review Report was Hawaii's first opportunity to "test-pilot" the newly established CDR system. The report focuses on all the deaths to children from birth to age 18 in the State of Hawaii during 1996. Inasmuch as the current database is limited in size, meaningful analysis by cause of death is difficult. Over time, the addition of yearly data will provide greater insight as to contributing factors to child death. Trends and patterns may be identified and directly related to specific risk behaviors. This information will be helpful in developing educational programs for increased community awareness and action. It will be possible to use the information to design and evaluate targeted strategies, and promulgate policies that reduce preventable deaths. During the analysis of the data and development of this report, strategies to improve both the Child Death Review system and the data were identified; these changes will be implemented in the future. Continued individual commitment by all stakeholders and sufficient levels of resources will be necessary to accomplish the mission of the Child Death Review system.

In the future, the information provided by the Child Death Review system will be further analyzed to provide greater insights and guidance. Some important areas for further study include the correlation between maternal factors and neonatal deaths, characterization of risk factors for vehicular death, drowning and assaults. Additionally, the effect of county of residence and ethnicity on risk for death will need to be fully investigated.

This report ends with one more mahalo to the members of the State Child Death Review Council and the Local Child Death Review Teams for their commitment to this work. Their accomplishments, for which no additional resources were allocated, are truly commendable. We look forward to continued collaboration and strategic gains for the improvement of the health and safety of the children of Hawaii.

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Appendix II

Data Forms 1 & 2

HAWAII CHILD DEATH REVIEW SYSTEM
DATA FORM 1

Directions: Refer to the Data Form Completion Instruction booklet while completing this form. **Fill in all blanks & data items except for Not/applicable data items**. To minimize inaccuracies, please write legibly in ink.

A. DEATH REVIEW TEAM INFORMATION

1a. REVIEW # (from case review sheet)

_____

1b. REVIEW DATE

_____/_____/_____
mm dd yyyy

2. AGENCIES INVOLVED IN REVIEW (check all that apply)

1☐ Attorney General's Office
2☐ Dept. of Education
3☐ Dept. of Health
4☐ Dept. of Human Services
5☐ Hospital: _____
6☐ Medical Examiner's Office
7☐ Physician: _____
8☐ Police Department: Coroner
9☐ Police Department
10☐ Prosecutor's Office
11☐ Emergency Medical Service
12☐ Fire Department
13☐ Other: _____
13☐ Other: _____
14☐ Public Health Nurse
15☐ Family Court

B. IDENTIFICATION OF THE CHILD (from death certificate)

3. DEATH CERTIFICATE NUMBER

_____
☐ Not/available

4. BIRTH CERTIFICATE NUMBER

_____
☐ Not/available
☐ Not/applicable

5. GENDER OF CHILD

f☐ Female
m☐ Male

6. DATE OFBIRTH

_____/_____/_____
mm dd yyyy

7.DATEOFDEATH

_____/_____/_____
mm dd yyyy

8. CHILD'S RESIDENCE AT TIME OF DEATH

_____
_____
street
_____
city
_____
island
_____
state
_____
zip code

9. PLACE WHERE DEATH OCCURRED (see D.C. 7a, 7b)

_____
_____
street
_____
city
_____
island
_____
state
_____
zip code

10. RACE AND ETHNICITY OF CHILD:

a. Hispanic origin? ☐ Yes ☐ No

b. Check all that apply:

1☐ Caucasian
2☐ Hawaiian
3☐ Part Hawaiian
4☐ Chinese
5☐ Filipino
6☐ Japanese
7☐ Puerto Rican
8☐ Korean
9☐ Samoan
10☐ Portuguese
11☐ Guamanian
12☐ American Indian
13☐ Black
14☐ Vietnamese
15☐ Other Asian: _____
15☐ Other Asian: _____
16☐ Other Pacific Islander: _____
16☐ Other Pacific Islander: _____
17☐ Cuban
18☐ Mexican
19☐ Asian Indian
21☐ Unstated
20☐ Other: _____
20☐ Other: _____
20☐ Other: _____
22☐ Refused
23☐ Unknown

c. Ethnic Code From Death Certificate:

C. SIGNIFICANT OTHERS

11. PERSONS WHO WERE PART OF THE CHILD'S IMMEDIATE FAMILY OR CONSISTENTLY INVOLVED IN THE CHILD'S LIFE (PRENATAL LIFE INCLUDED), INCLUDING E.G., PARENT'S BOYFRIEND/GIRLFRIEND & OTHERS WHO MAY HAVE LIVED IN THE SAME HOUSEHOLD. **(Check all that apply. Write in N/A if age is not available)**

11a. Relationship	11b. Age	12. Live with the child at time of death?
1☐ Mother	_____	☐
2☐ Father	_____	☐
3☐. Mother's boyfriend/partner	_____	☐
4☐ Father's girlfriend/partner	_____	☐
5☐ Foster mother	_____	☐
6☐ Foster father	_____	☐
7☐ Step-father	_____	☐
8☐ Step-mother	_____	☐
9☐ Sister	_____	☐
10☐ Brother	_____	☐
11☐ Grandmother	_____	☐
12☐ Grandfather	_____	☐
13☐ Uncle	_____	☐
14☐ Aunt	_____	☐
15☐ Male child	_____	☐
16☐ Female child	_____	☐
19☐ Male friend	_____	☐
20☐ Female friend	_____	☐
25☐ Sibling	_____	☐
☐ Other relative: _____	_____	☐
☐ Other: _____	_____	☐
☐ : _____	_____	☐

13. RELATIONSHIP OF CHILD'S PARENTS:

1☐ Married 2☐ Not married 3☐ Separated 4☐ Divorced 5☐ Widowed c☐ Unknown

D. CAREGIVER(S) HISTORY

Complete for persons with whom the child lived prior to death or fatal injury & who were principally responsible for the care of the child. Check all persons that apply.

14a. WHO WERE THE CAREGIVERS (check all that apply):

1☐ Mother 2☐ Father 3☐ Baby sitter
4☐ Other caregiver: _____
b☐ no **(go to #16)**
c☐ unknown **(go to #16)**

14b. PARENT(S)/CAREGIVER HAVE AHISTORY OF THE FOLLOWING?

(Check all that apply to persons identified above):

1☐ ☐ ☐ ☐ Drug abuse/addiction
2☐ ☐ ☐ ☐ Alcohol abuse/addiction
3☐ ☐ ☐ ☐ Mental illness
4☐ ☐ ☐ ☐ Domestic violence
5☐ ☐ ☐ ☐ Developmental disability
6☐ ☐ ☐ ☐ Other: _____
b☐ No c☐ Unknown

15. SOURCE(S) DOCUMENTING IMPAIRMENT IDENTIFIED IN #14

(Check all that apply):

1☐ ☐ ☐ ☐ Official record (e.g., conviction, treatment)
2☐ ☐ ☐ ☐ Professional observation (e.g., social worker, law enforcement)
3☐ ☐ ☐ ☐ Non-professional observation (e.g., neighbor, friend, etc.)
4☐ ☐ ☐ ☐ Self-report

b☐ No c☐ Unknown

16 DO THE PARENTS OR THE CAREGIVER HAVE A HISTORY OF OTHER CHILD DEATHS UNDER THEIR CARE?

☐ yes: check all that apply:: 1☐ Mother 2☐ Father 3☐ Baby sitter
4☐ Other caregiver: _____

☐ no ☐ unknown

E. INFANT DEATHS INCLUDING SIDS (For infant deaths under 1 year of age only. All other deaths go to CHILD/FAMILY COMMUNITY HISTORY section.)

17**a.** MOTHER'S PREVIOUS PREGNANCIES:

☐ yes (enter # of pregnancy): _____
☐ none **(go to #19)** ☐ unknown

b. History of prematurity?
a☐ Yes
b☐ No
c☐ Unknown

18 OUTCOME OF PREVIOUS PREGNANCIES **(check all that apply)**

1☐ Birth, kept child
2☐ Birth, placed child with other family (e.g., foster care, grandparents, etc.)
3☐ Miscarriage
4☐ Abortion
5☐ Died during delivery or at hospital
6☐ Other: _____
6☐ Other: _____
c☐ Unknown

19. DID THE MOTHER HAVE PRENATAL CARE DURING HER PREGNANCY?

☐ yes: enter # of prenatal visits:____ or ☐ unknown visits
☐ no ☐ unknown

20. GESTATIONAL AGE AT BIRTH: _____ weeks ☐ unknown

21. APGAR SCORE: **a.** 1 minute: _____ **b.** 5 minutes: _____ ☐ unknown

22. BIRTH WEIGHT

_____
(in grams)

23. MOTHER'S AGE AT TIME OF DELIVERY:

_____ years

24. SUBSTANCES USED DURING PREGNANCY **(check all that apply):**

1☐ Alcohol
2☐ Tobacco
3☐ Marijuana
4☐ Crystal methamphetamine
5☐ Cocaine
6☐ Other: _____
6☐ Other: _____
b☐ None
c☐ Unknown

25a. ABNORMAL CONDITIONS OF THE NEWBORN **(check all that apply):**

1☐ Anemia hematocrit
2☐ Assisted ventilation
3☐ Birth injury
4☐ Congenital birth defect
5☐ Fetal alcohol syndrome
6☐ Hyaline membrane disease
7☐ Meconium aspiration syndrome
8☐ Seizures
9☐ Other: _____
9☐ Other: _____
b☐ None
c☐ Unknown

26. WAS THE INFANT CONSIDERED BY THE PHYSICIAN TO BE DEVELOPING APPROPRIATELY FOR ITS AGE (e.g., growth, motor skills, etc.)?

☐ yes ☐ no (explain): _____ ☐ unknown

F. CHILD/FAMILY HISTORY

27**a.** PARENTS ACTIVE U.S. MILITARY?

☐ yes (specify branch as bellow) ☐ no ☐ unknown

1☐ Air Force 2☐ Army 3☐ Marine Corps 4☐ Navy 5☐ Coast Guard 6☐ National Guard

b. Subinstallation number: _____ ☐ unknown ☐ not/applicable

28. **a.** DID THE CHILD HAVE HEALTH INSURANCE?

a☐ Yes b☐ No c☐ Unknown **b.** If Yes, specify health plan: _____

29. WAS THE CHILD ENROLLED IN SCHOOL?

☐ Yes: 1☐ Day care/preschool 2☐ Kindergarten through 12 grade

b☐ No c☐ Unknown e☐ Not/applicable **(go to #31)**

30. DID CHILD HAVE HISTORY OF **(check all that apply)**:

1☐ Behavioral difficulties/problems 5☐ Suspension 8☐ Other:_____

2☐ Delinquency 6☐ Poor attendance 8☐ Other:_____

3☐ Expulsions 7☐ Development delay b☐ None

4☐ Learning difficulty 8☐ Other:_____ c☐ Unknown

31. DID THE CHILD HAVE ANY CHRONIC ILLNESS SINCE BIRTH

☐ yes (explain): _____

☐ no ☐ unknown

32. ANY CHRONIC ILLNESS RIGHT BEFORE DEATH?

☐ yes (explain): _____

☐ no ☐ unknown

33. HAS THE CHILD/FAMILY HAD PRIOR INVOLVEMENT WITH CPS?

☐ yes (explain):_____

☐ no ☐ unknown

34. WAS THERE AN OPEN, RELATED CPS CASE (child or family) AT TIME OF DEATH

☐ yes (explain):_____

☐ no ☐ unknown

35. WERE SIBLINGS REMOVED, IF ANY, BY CPS?

a☐ Yes b☐ No c☐ Unknown e☐ Not/applicable

36. HAVE OTHER SIBLINGS UNDER AGE 18 IN THE FAMILY DIED?

☐ yes (specify cause of death): _____ ☐ no ☐ unknown ☐ not/applicable

37. DID CHILD OR FAMILY UTILIZE OTHER SERVICES & PREVENTION AGENCIES ONE YEAR BEFORE DEATH (e.g., Head Start, Zero-to-Three, Hale Kipa, Parents & Children Together, Dept. of Human Services, etc.)?

☐ yes ☐ no ☐ unknown

If yes, agencies: _____ services: _____

agencies: _____ services: _____

agencies: _____ services: _____

38. CHILD ADJUDICATED FOR LAW VIOLATION?

a☐ Yes

b☐ No

c☐ Unknown

e☐ Not/applicable

39. ANY PRIOR FAMILY COURT ACTION OR INVOLVEMENT WITH CHILD?

☐ Yes (explain): _____

☐ no ☐ unknown

40. ANY PRIOR FAMILY COURT ACTION OR INVOLVEMENT WITH FAMILY?

☐ Yes (explain): _____

☐ no ☐ unknown

41. PRIOR POLICE INVOLVEMENT WITH THIS CHILD OR FAMILY?

☐ Yes (explain): _____

☐ no ☐ unknown

G. DEATH INFORMATION

42. TIME OF INCIDENT: _____ a.m. / p.m. ☐ unknown ☐ not applicable

43. TIME OF DEATH: _____ a.m. / p.m. ☐ unknown

44. WHO CONDUCTED THE DEATH SCENE INVESTIGATION? (check all that apply)

1☐ Medical examiner
2☐ Coroner
3☐ Law enforcement
4☐ Other: _____
4☐ Other: _____
c☐ Unknown
e☐ Not/applicable

47. WHO REPORTED THE DEATH?

1☐ Mother
2☐ Father
3☐ Mother's boyfriend/partner
4☐ Father's girlfriend/partner
5☐ Foster mother
6☐ Foster father
7☐ Step-father
8☐ Step-mother
9☐ Sister
10☐ Brother
☐ : _____
c☐ Unknown

45. PREMISES WHERE DEATH OCCURRED

1☐ Child's residence
2☐ Baby sitter's residence
3☐ Other residence:
_____
4☐ Highway
5☐ City street
6☐ Rural road
7☐ Sidewalk
8☐ Childcare center
9☐ Other 24-hour licensed care:
_____
10☐ School
11☐ Park/public playground
12☐ Hospital/health care facility
13☐ Ocean
14☐ Body of water:
_____
15☐ Other:
_____
c☐ Unknown

46. WHO WAS PRESENT AT THE TIME OF DEATH OR FATAL INJURY? (check all that apply)

1☐ Mother
2☐ Father
3☐ Mother's boyfriend/partner
4☐ Father's girlfriend/partner
5☐ Foster mother
6☐ Foster father
7☐ Step-father
8☐ Step-mother
9☐ Sister (age: _____)
10☐ Brother (age: _____)
11☐ Grandmother
12☐ Grandfather
15☐ Male child (age: _____)
16☐ Female child (age: _____)
17☐ Baby sitter
18☐ Caregiver
21☐ Stranger
☐ : _____
☐ : _____
☐ : _____
☐ : _____
☐ : _____
e☐ Not/applicable

48. WAS THE PERSON(S) IDENTIFIED IN #46 ABOVE ASLEEP, DISTRACTED, OR PREOCCUPIED AT THE TIME OF THE CHILD'S DEATH OR FATAL INJURY?

1☐ ☐ ☐ Asleep (comment): _____
2☐ ☐ ☐ Distracted (comment): _____
3☐ ☐ ☐ Preoccupied (comment): _____
4☐ ☐ ☐ Other (comment): _____
☐ no ☐ unknown ☐ not/applicable

49. DID THE PERSON(S) IDENTIFIED IN #46 APPEAR TO BE INTOXICATED, UNDER THE INFLUENCE OF DRUGS, MENTALLY ILL, OR OTHERWISE IMPAIRED AT THE TIME OF THE CHILD'S DEATH OR FATAL INJURY?

1☐ ☐ ☐ Intoxicated by alcohol (comment): _____
2☐ ☐ ☐ Influence of drug (comment): _____
3☐ ☐ ☐ Mentally ill (comment): _____
4☐ ☐ ☐ Other (comment): _____
☐ ☐ no ☐ unknown ☐ not/applicable

50. PLACE OF INJURY IF DIFFERENT FROM PLACE OF DEATH (fill in only those items that are different from place of death if applicable)

Street: _____ city: _____ island: _____

state: _____ zip code: _____ ☐ unknown ☐ not/applicable

51. PREMISES WHERE INJURY OCCURRED (if different from premise where death occurred)

1☐ Child's residence	7☐ Sidewalk	13☐ Ocean
2☐ Baby sitter's residence	8☐ Childcare center	14☐ Body of water: _____
3☐ Other residence _____	9☐ Other 24-hour licensed care: _____	15☐ Other: _____
4☐ Highway	10☐ School	
5☐ City street	11☐ Park/playground	16☐ Unknown
6☐ Rural road	12☐ Hospital/health care facility	17☐ Not/applicable

H. AUTOPSY (If available, attach autopsy report on the back of page 12)

52. CASE STATUS

1☐ Medical examiner case
2☐ Coroner case
3☐ Neither
4☐ Private MD

53. AUTOPSY PERFORMED

☐ yes ☐ no

55. PHYSICAL DEVELOPMENT

☐ Abnormal for age (describe): _____

☐ Normal for age ☐ unknown

54. NUTRITIONAL STATUS

1☐ Malnourished
2☐ Normal range
3☐ Obese
c☐ Unknown

56. AUTOPSY FINDINGS

Describe: _____

☐ not/applicable

I. CATEGORY OF DEATH

57. MANNER OF DEATH (from death certificate): 1☐ Natural 2☐ Unintentional 3☐ Homicide 4☐ Suicide 5☐ Undetermined 6☐ Not stated on death certificate

58. CAUSE OF DEATH (from death certificate)

a. Immediate cause: _____

b. Due to, or as a consequence of: _____

c. Due to, or as a consequence of: _____

d. Underlying ICD-9 Codes: _____

59. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN #58 (from death certificate): ☐ not/applicable

_____

60. **CAUSES & CIRCUMSTANCES OF DEATH** (Please identify the primary category of death. Then check box to indicate cause of death. If more than one cause, # immediate cause as #1 and all other contributing causes as #2 and so forth. Under cause, check one circumstance box under each section that applies unless otherwise indicated. Complete descriptions by filling in blanks).

Primary Category of Death (please select only one):

1☐ Confinement
2☐ Drowning
3☐ Electrocution
4☐ Falls
5☐ Firearm
6☐ Fire/burn
7☐ Illness/other natural death
8☐ Lack of adequate care
9☐ Physical assault
10☐ Poisoning/overdose
11☐ SIDS
12☐ Suffocation/asphyxiation
13☐ Suicide
14☐ Vehicular
15☐ Other
24☐ Undetermined
26☐ Homicide

1☐ Confinement

a) Place of confinement: ☐ Chest, box, foot locker ☐ Motor vehicle ☐ Refrigerator/appliance ☐ Room or building ☐ Other: _____ ☐ unknown

2☐ Drowning

a) Place of drowning:
☐ Ocean
☐ Swimming pool/wading pool
☐ Bathtub/bucket
☐ Other: _____
☐ unknown

b) Location prior to drowning:
☐ Beach
☐ Boat
☐ Other: _____
☐ unknown

c) Wearing floatation device?
a☐ Yes
b☐ No
c☐ Unknown
d☐ Not/applicable

d) Lifeguard in attendance?
a☐ Yes
b☐ No
c☐ Unknown
e☐ Not/applicable

e) If death site was residential pool:
-- pool totally enclosed by fence? a☐ Yes b☐ No c☐ Unknown
-- fence around backyard? a☐ Yes b☐ No c☐ Unknown
-- problem with fencing? a☐ Yes b☐ No c☐ Unknown
e☐ Not applicable

3☐ Electrocution

a) Cause of electrocution:
☐ Water contact
☐ Electrical wire
☐ Electrical outlet
☐ Appliance
☐ Tool
☐ Other: _____
☐ unknown
☐ not/applicable

b) Electrical source defective?
a☐ Yes
b☐ No
c☐ Unknown

4☐ Falls

a) Decedent fell from:
☐ Furniture
☐ Lanai
☐ Natural elevation
☐ Open window
☐ Recreational equipment
☐ Height of fall:
☐ Roof
☐ Stairs/steps
☐ Tree
☐ Other: _____
☐ unknown

b) Landing surface composition/hardness:
☐ Describe: _____
☐ unknown
☐ not/applicable

CAUSES & CIRCUMSTANCES OF DEATH CONTINUED

5☐ **Firearm**

a) Firearm handled by decedent:
1☐ Handgun
2☐ Shotgun
c☐ Unknown
e☐ Not/applicable

b) Who owned the firearm handled by decedent?
1☐ Decedent
2☐ Parent
3☐ Other family member
4☐ Friend
c☐ Unknown e☐ Not/applicable

c) Firearm handled by other Person:
1☐ Handgun
2☐ Shotgun
c☐ Unknown
e☐ Not/applicable

d) Who owned the firearm handled by other person?
1☐ Decedent
2☐ Parent
3☐ Other family member
4☐ Friend
c☐ Unknown
e☐ Not/applicable

e) Use of firearm at the time of the incident:
☐ Shooting at person
☐ Cleaning
☐ Loading
☐ Hunting
☐ Target shooting
☐ Playing
☐ Other: _____
☐ unknown

f) Did person handling firearm attend safety classes?
a☐ Yes b☐ No c☐ Unknown

g) Age of person handling firearm if other than decedent: _____ years
☐ unknown

6☐ **Fire/Burn**

a) Source of ignition/fire
☐ Oven/stove
☐ Other cooking appliance
☐ Matches
☐ Lighter
☐ Lit cigarette
☐ Electrical wire
☐ Fireworks ☐ Explosives
☐ Other: _____ ☐ unknown ☐ not/applicable

b) Source of non-fire burn:
☐ Hot water
☐ Appliance
☐ Other: _____
☐ unknown
☐ not/applicable

c) Was there a smoke alarm present at the fire scene?
a☐ Yes
b☐ No
c☐ Unknown
e☐ Not/applicable

d) If alarm was present, did it sound?
a☐ Yes
b☐ No
c☐ Unknown
e☐ Not/applicable

e) If the fire was started by a person, what was the activity?
☐ Playing
☐ Smoking
☐ Cooking
☐ Other: _____
☐ unknown
☐ not/applicable

f) Type of construction of building burned:
☐ Wood frame
☐ Brick/stone
☐ Other: _____
☐ unknown
☐ not/applicable

7☐ **Illness/Other Natural Death**

☐ Cause of death: _____
☐ As a consequence of: _____

Primary Category of Death for illness/other natural death (please select only one):

16☐ Acute illness
17☐ Birth injury
18☐ Cancer
19☐ Chronic disease/illness
20☐ Congenital anomalies
21☐ Genetic anomalies
22☐ Prematurity
23☐ Status post surgical procedures
25☐ Other natural death

8☐ **Lack of Adequate Care:**

a) ☐ Apparent lack of supervision
☐ Apparent lack of care (specify): ☐ Delayed medical care ☐ Unplanned out-of-hospital birth
☐ Lack of medical attention ☐ Malnutrition or dehydration ☐ Other: _____

CAUSES & CIRCUMSTANCES OF DEATH CONTINUED

9☐ **Physical Assault**

a) Type of injury/assault:
- ☐ Shaken
- ☐ Struck
- ☐ Cut/stabbed
- ☐ Thrown/pushed
- ☐ Other: _____
- ☐ unknown

b) Weapon used:
- ☐ Knife
- ☐ Sharp object
- ☐ Blunt object
- ☐ Hands/feet
- ☐ Other: _____
- ☐ unknown

c) Precipitating events (check all that apply):
- 1☐ Random
- 2☐ During the course of another crime
- 3☐ Disciplining
- 4☐ Toilet training
- 5☐ Crying/whining child
- 6☐ Revenge towards another
- 7☐ Other: _____
- 7☐ Other: _____
- c☐ Unknown

10☐ **Poisoning/Overdose**

a) Type of poisoning:
- ☐ Household cleaning substance
- ☐ Prescription medication
- ☐ Non-prescription medication
- ☐ Illegal drug:
  - ☐ Heroin
  - ☐ Cocaine
  - ☐ Methamphetamine
  - ☐ Other: _____
- ☐ Alcohol
- ☐ Carbon monoxide inhalation
- ☐ Other: _____
- ☐ unknown

b) Safety cap on bottle:
- a☐ Yes
- b☐ No
- c☐ Unknown
- e☐ Not applicable

c) Location of drug or chemical:
- ☐ In cabinet with locks or safety latch
- ☐ In cabinet without locks or safety latch
- ☐ On counter, table or floor
- ☐ Other: _____
- ☐ unknown
- ☐ not applicable

11☐ **Sudden Infant Death Syndrome**

a) Position of infant at discovery:
- ☐ On stomach, face down
- ☐ On stomach, face to side
- ☐ On back
- ☐ On side
- ☐ Other: _____
- ☐ unknown

b) Sleeping place:
- 1☐ soft mattress
- 2☐ firm/hard mattress
- c☐ Unknown

c) Smoke-free environment?
- a☐ Yes
- b☐ No
- c☐ Unknown

d) Breastfed?
a☐ Yes b☐ No c☐ Unknown

12☐ **Suffocation/Asphyxiation/Strangulation**

a) Object impeding breath:
- ☐ Food
- ☐ Small object or toy in mouth
- ☐ Other person's hand(s)
- ☐ Object (e.g., plastic bag) covering mouth/nose
- ☐ Object (e.g., rope) exerting pressure on neck
- ☐ Other: _____
- ☐ unknown
- ☐ not/applicable

b) Location of child at the time:
- 1☐ In crib
- 2☐ In bed alone
- 3☐ In bed with others
- 4☐ Being cradled
- b☐ Unknown
- e☐ Not/applicable

d) Position of child at discovery:
- ☐ On stomach, face down
- ☐ On stomach, face to side
- ☐ On side
- ☐ On back
- ☐ Other: _____
- ☐ unknown

c) If in crib/bed, incident due to:
- ☐ Hazardous design of crib/bed
- ☐ Malfunction/improper use of crib/bed
- ☐ Placement on soft surface (e.g., waterbed)
- ☐ Other: _____
- ☐ unknown
- ☐ not/applicable

e) Incident due to carbon monoxide inhalation?
a☐ Yes b☐ c☐ Unknown

CAUSES & CIRCUMSTANCES OF DEATH CONTINUED

13☐ **Suicide**

a) History of prior suicide attempt(s)?
a☐ Yes
b☐ No
c☐ Unknown

d) History of alcohol and/or drug abuse?
a☐ Yes b☐ No c☐ Unknown

e) History of runaway?
a☐ Yes b☐ No c☐ Unknown

b) Which of the following may have contributed to the suicide? (check all that apply):
☐ Breakup/argument with boyfriend/girlfriend
☐ Argument with parent(s)
☐ Problem in school (academically & socially)
☐ Failed accomplishment
☐ History of depression
☐ Violent family life
☐ Death of loved one
☐ Other: _____
☐ unknown

c) Mechanism of suicide:
☐ Household cleaning substance
☐ Prescription medication
☐ Non-prescription medication
☐ Weapon (type used): _____
☐ Object (type used): _____
☐ Carbon monoxide inhalation
☐ Other: _____
☐ unknown

14☐ **Vehicular**

a) Type of vehicle of:

1) decedent		2) other driver
☐	Car	☐
☐	Truck	☐
☐	Moped/scooter	☐
☐	All-terrain vehicle	☐
☐	Bicycle	☐
☐	Motorcycle	☐
☐	Other: _____	☐
☐	Van	☐
☐	unknown	☐

b) Position of decedent, if occupant (mark all that apply):
1☐ Front seat
2☐ Rear seat
3☐ Truck bed/other
4☐ Left side of vehicle
5☐ Middle
6☐ Right
7☐ Facing forwards
8☐ Facing backwards
c☐ Unknown e☐ Not/applicable

c) What was decedent?
☐ Occupant
☐ Driver
☐ Pedestrian
☐ Bicyclist
☐ Other: _____
☐ unknown
☐ not/applicable

d) Condition of road:
☐ Normal
☐ Wet
☐ Loose gravel
☐ Other: _____
☐ unknown

e) Safety restraint (safety seat or seatbelt)
1☐ Available, used
2☐ Available, not Used
d☐ Not/available
c☐ Unknown

f) Decedent wearing helmet?
a☐ Yes
b☐ No
c☐ Unknown
d☐ Not/applicable

g) Decedent in crosswalk?
a☐ yes
b☐ no
c☐ Unknown
e☐ Not/applicable

h) Vehicle in which decedent was the occupant/operator:
☐ Operator driving intoxicated ☐
☐ Speed/recklessness indicated: ☐
Actual speed: _____ (mph)
Speed limit: _____ (mph)
☐ Other violation by operator ☐
☐ Brake failure ☐
☐ Other mechanical failure ☐
☐ Other: _____ ☐
☐ unknown ☐
☐ not/applicable ☐

i) Vehicle by which decedent was hit:

k) Who was responsible for the accident?
1☐ Decedent
2☐ Driver in decedent's vehicle
3☐ Driver in other vehicle
4☐ Other: _____

15☐ **Other Category** (describe the causes and circumstances):

_____

_____

J. SUSPECT(S) (If not applicable, go to ADDITIONAL INFORMATION Section K.)

61. WAS A SUSPECT IDENTIFIED? (Suspect: any person thought to be responsible for child's death.)	62. IF THE SUSPECT(S) IS **PARENT OR CAREGIVER**, DO THEY HAVE A HISTORY OF PERPETRATING ABUSE OR NEGLECT?	63. IF THE SUSPECT(S) IS **PARENT OR CAREGIVER**, DO THEY HAVE A HISTORY OF PREVIOUS CRIMINAL CHARGES, ARRESTS OR CONVICTIONS
☐ Yes (check all that apply): 1☐ Father 2☐ Mother 3☐ Caregiver 4☐ Stranger 5☐ Other: _____ b☐ No (**go to #65**) c☐ Unknown (**go to #65**)	a☐ ☐ ☐ ☐ Yes b☐ ☐ ☐ ☐ No c☐ ☐ ☐ ☐ Unknown	a☐ ☐ ☐ ☐ Yes b☐ ☐ ☐ ☐ No c☐ ☐ ☐ ☐ Unknown

64. IF SUSPECT IS **OTHER THAN PARENT(S) OR CAREGIVER**, COMPLETE THE FOLLOWING:

a. Under the influence of drugs:	a☐ Yes	b☐ No	c☐ Unknown
b. Under the influence of alcohol:	a☐ Yes	b☐ No	c☐ Unknown
c. Mental illness:	a☐ Yes	b☐ No	c☐ Unknown
d. Gang related:	a☐ Yes	b☐ No	c☐ Unknown

65. WAS THERE A LAW ENFORCEMENT INVESTIGATION?

☐ yes: (outcome): _____

☐ no ☐ unknown

66. WAS THE CASE PRESENTED TO A PROSECUTING ATTORNEY?

☐ yes: (outcome): _____

_____

☐ no (reason): ☐ Non-suspicious death ☐ Suicide ☐ Other: _____

☐ unknown

K. ADDITIONAL INFORMATION

67. Provide any additional information describing the factors contributing to understanding this child's death and that may help to more completely describe circumstances related to the death (e.g., gang related, substance abuse, etc.), the delivery of services, and prevention. (Use back of this sheet if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

_____

L. DEATH REVIEW TEAM FINDINGS

68. MANNER OF DEATH CONSISTENT WITH THE DEATH CERTIFICATE?

a. Death certificate:	**b.** Team's finding:
1☐ natural	1☐ Natural
2☐ unintentional	2☐ Unintentional
3☐ homicide	3☐ Homicide
4☐ suicide	4☐ Suicide
5☐ undetermined	5☐ Undetermined
6☐ not stated on death certificate	0☐ Consistent with the death certificate

69. **a**. CAUSE OF DEATH CONSISTENT WITH THE DEATH CERTIFICATE?

☐ Yes ☐ no (team's finding on the cause of death): _____

_____

b. CHILD ABUSE/NEGLECT INDICATED IN THIS CASE?

Abuse: ☐ no ☐ Yes (comment): _____

_____

Neglect: ☐ no ☐ Yes (comment): _____

70. PRIME RISK FACTORS INVOLVED IN CHILD'S DEATH (check all that apply):

1☐ Medical: _____
9☐ Prenatal: _____
2☐ Economical: _____
3☐ Product Safety: _____
10☐ Safety practice: _____
4☐ Social: _____
5☐ Drugs/alcohol: _____
6☐ Environmental: _____
7☐ Behavioral: _____
8☐ Other: _____
8☐ Other: _____
b☐ None **(go to #73)**
c☐ Unknown

71. WERE THESE RISK FACTORS IDENTIFIED IN THE COMMUNITY PRIOR TO THIS DEATH?

A☐ Yes b☐ No c☐ Unknown

72. WAS ANY ACTION TAKEN IN THE COMMUNITY TO ADDRESS THE RISK FACTORS PRIOR TO THIS DEATH?

a☐ Yes b☐ No c☐ Unknown

73. TO WHAT DEGREE WAS THIS DEATH BELIEVED TO BE PREVENTABLE?

(Preventable death is defined as one in which awareness, education, or action by an individual or a community may have changed the circumstances that led to death.)

1☐ Not at all **(go to #75)** 2☐ Maybe 3☐ Definitely

74a. WHAT RECOMMENDED ACTIONS CAN BE TAKEN TO PREVENT THIS TYPE OF DEATH (check all that apply)?

1☐ Agency policy/practice: _____
5☐ Legislation, law or ordinance: _____
2☐ Community safety project: _____
7☐ Product safety awareness: _____
13☐ Safety practice: _____
3☐ Educational activities in the media: _____
4☐ Educational activities in school: _____
6☐ News services: _____
8☐ Public forums: _____
9☐ Improved resources: _____
9☐ Improved resources: _____
10☐ Other: _____
10☐ Other: _____
11☐ Improvement of medical care: _____
12☐ Improvement of prenatal care: _____
b☐ None

M. REVIEW PROCESS

75. Please comment on **this** child death review process experience (e.g., problems encountered or the positive effects of the review) and how it can be improved.

_____
_____
_____
_____
_____
_____
_____
_____
_____

HAWAII CHILD DEATH REVIEW SYSTEM
DATA FORM 2

DEATH SCREENING INFORMATION

1a. REVIEW # (from case review sheet)
_____

1b. SCREENING DATE
_____/_____/_____
mm dd yyyy

2. DATE OF DEATH
_____/_____/_____
mm dd yyyy

3. PARENTS/GUARDIAN ACTIVE U.S. MILITARY?
☐ Yes (specify branch of service):
1☐ Air Force 4☐ Navy
2☐ Army 5☐ Coast Guard
3☐ Marine Corps 6☐ National Guard
b☐ No c☐ Unknown

IDENTIFICATION OF THE CHILD (from death and/or birth certificate)

4. DEATH CERTIFICATE NUMBER
_____
☐ Not/available

5. BIRTH CERTIFICATE NUMBER
_____
☐ Not/available
☐ Not/applicable

6. GENDER OF CHILD
f☐ Female
m☐ Male

7. DATE OF BIRTH
_____/_____/_____
mm dd yyyy

8. CHILD'S RESIDENCE AT TIME OF DEATH street: _____
island: _____ city: _____ state: _____ zip code: _____

9. PLACE WHERE DEATH OCCURRED street: _____
island: _____ city: _____ state: _____ zip code: _____

If military death: subinstallation #: _____ If # is unknown, check here: ☐

10. ETHNICITY OF CHILD
a. Hispanic origin? ☐ yes ☐ no
b. Check all that apply:

1☐ Caucasian
2☐ Hawaiian
3☐ Part Hawaiian
4☐ Chinese
5☐ Filipino
6☐ Japanese
7☐ Puerto Rican
8☐ Korean
9☐ Samoan
10☐ Portuguese
11☐ Guamanian
12☐ American Indian
13☐ Black
14☐ Vietnamese
15☐ Other Asians: _____
15☐ Other Asians: _____
16☐ Other Pacific Islander: _____
16☐ Other Pacific Islander: _____
17☐ Cuban 18☐ Mexican 19☐ Asian Indian
20☐ Other: _____
20☐ Other: _____
21☐ Unstated 22☐ Refused 23☐ Unknown

c. Ethnic code from death certificate: _____

CATEGORY OF DEATH

11. MANNER OF DEATH (from death certificate): 1☐ Natural 2☐ Unintentional
3☐ Homicide 4☐ Suicide 5☐ Undetermined 6☐ Not stated on death certificate

12. CAUSE OF DEATH (from death certificate):
a. Immediate cause: _____
b. Due to, or as a consequence of: _____
c. Due to, or as a consequence of: _____
d. Underlying ICD-9 Codes: _____

13. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN #11: ☐ not/applicable

14a. WAS CHILD UNDER THE CARE OF A PHYSICIAN? a☐ Yes b☐ No c☐ Unknown
b. If yes or no, explain: _____

Appendix III

Session Laws of Hawaii
Act 369

SESSION LAWS OF HAWAII

NINETEENTH STATE LEGISLATURE

REGULAR SESSION OF 1997

A Bill for an Act Relating to Child Death Review.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 321, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read as follows:

"PART . CHILD DEATH REVIEW

§321- Multidisciplinary and multiagency reviews. The department of health may conduct multidisciplinary and multiagency reviews of child deaths in order to reduce the incidence of preventable child deaths.

§321- Definitions. As used in this part:

"Child" means a person under eighteen years of age.

"Child death review information" means information regarding the child and child's family, including but not limited to:

(1) Social, medical, and legal histories;
(2) Death and birth certificates;
(3) Law enforcement investigative data;
(4) Medical examiner or coroner investigative data;
(5) Parole and probation information and records;
(6) Information and records of social service agencies;
(7) Educational records; and
(8) Health care institution information.

"Department" means the department of health.

"Director" means the director of health or the director's designated representatives

"Family" means:

(1) Each legal parent;
(2) The natural mother;
(3) The natural father;
(4) The adjudicated, presumed, or concerned natural father as defined under section 578-2;

(5) Each parent's spouse or former spouses;
(6) Each sibling or person related by consanguinity or marriage;
(7) Each person residing in the same dwelling unit; and
(8) Any other person who, or legal entity that, is a child's legal or physical custodian or guardian, or who is otherwise responsible for the child's care, other than an authorized agency that assumes such a legal status or relationship with the child under chapter 587.

"Preventable death" means a death that reasonable medical, social, legal, psychological, or educational intervention may have prevented.

"Provider of medical care" means any health care practitioner who provides, or a facility through which is provided, any medical evaluation or treatment, including dental and mental health evaluation or treatment.

§321- Access to information. (a) Upon written request of the director, all providers of medical care and state and county agencies shall disclose to the department, and those individuals appointed by the director to participate in the review of child deaths, child death review information regarding the circumstances of a child's death so that the department may conduct a multidisciplinary and multiagency review of child deaths pursuant to section 321-31 and this part.

(b) To the extent that this section conflicts with other state confidentiality laws, this section shall prevail.

§321- Exception. Information regarding an ongoing civil or criminal investigation shall be disclosed at the discretion of the applicable state, county, or federal law enforcement agency.

§321- Use of child death review information and records. (a) Except as otherwise provided in this part, all child death review information acquired by the department during its review of child deaths pursuant to this part, is confidential and may only be disclosed as necessary to carry out the purposes of this part.

(b) Child death review information and statistical compilations of data that do not contain any information that would permit the identification of any person shall be public records.

(c) No individual participating in the department's multidisciplinary and multiagency review of a child's death may be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a child death review meeting. Nothing in this subsection shall be construed to prevent a person from testifying to information obtained independently of the department's multidisciplinary and multiagency review of a child's death, or which is public information, or where disclosure is required by law or court order.

(d) Child death review information held by the department as a result of child death reviews conducted under this part are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that child death review information otherwise available from other sources is not immune fron' subpoena, discovery, or introduction into evidence through those sources solely because they were provided as required by this part.

§321- Immunity from liability. All agencies and individuals participating in the review of child deaths pursuant to this part shall not be held civilly or criminally liable for providing the information required under this part."

SECTION 2. This Act shall take effect upon its approval.

(Approved July 3, 1997.)

“A lei that is never cast aside is one’s child.”

Hawaiian proverb